In Motion Therapy
611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com
P 970-249-1646
F 970-249-8899

Patient Information

Date: _____

Patient name First _____ Middle Initial _____ Last _____
Address _____ City _____ State _____ Zip _____
Date of birth _____ Age _____ Sex _____ Marital status _____
Social Security # _____ Height _____ Weight _____
Best Phone # _____ **Text Reminder?** ☐ **OR Call Reminder?** ☐
Secondary Phone # _____ Email address _____
Employer _____ Work # _____
Emergency Contact: _____ Relationship to Patient _____
Phone # _____ Cell # _____ Work # _____
Who may we speak with regarding your care?
Name _____ Phone _____ Relationship _____
Referring provider's name _____ Phone # _____
Primary Care Physician name _____ Phone # _____
How did you hear about us? _____
Physician Friend Family Social Media

Responsible Party Information (under 18 years of age)

Name First _____ Middle Initial _____ Last _____
Date of birth _____ Relationship to patient _____

Insurance Information

Are you covered by Colorado Medicaid? _____ **Are you applying for Colorado Medicaid**? _____
Are you covered by health insurance? _____ If no, please make payment arrangements with our billing department.
Primary Insurance _____ Policy # _____ Group # _____
Policy Holder Name _____ Policy Holder Date of Birth _____
Secondary Insurance _____ Policy # _____ Group # _____
Policy Holder Name _____ Policy Holder Date of Birth _____
Is this an Auto accident? _____ **Is this Workers Compensation?** _____ Claim # _____
Date of Injury _____ Adjuster First and Last Name _____ Adjuster Phone _____

Consent for Payment

I hereby authorize payment of medical benefits billed to my insurance by In Motion Therapy. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I understand that any unpaid balances will be my responsibility and I may be charged interest of 1.5% per month for unpaid amounts 90 days past due.

__We require a 24 hour notice for cancellations.__ If you do not call to cancel or fail to show for an appointment you may be charged a rescheduling fee. If you miss 3 consecutive appointments we will notify your physician and will require you to obtain a new referral in order to continue your treatment.

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient _____ Relationship of Representative to Patient _____

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Patient name _____

About Your Therapy Needs

What is the problem that brings you to therapy? _____Circle: Right Left Both
When and **How** did this problem first occur? (Date of onset) _____
Did you have **surgery** for this problem? If so, please list with **date of surgery and location.** _____
_____

About Your Pain: 0 (no pain) to 10 (unbearable)

Current _____/10 Getting Better? ☐ What makes your pain better? _____
At best _____/10 Getting Worse? ☐ What makes your pain worse? _____
At worst _____/10 Staying the same? ☐

Circle all that apply:
Burning Sharp Dull/Achy Throbbing Shooting Numbness/Tingling
Constant Intermittent Worse in AM Worse in PM other: _____

Are any of your daily activities affected? If so, how? _____

Imaging/Surgeries

Have you had any **diagnostic tests** for this problem? If so, please list with dates _____
Have you had any **X-rays** for this problem? If so, please list with dates _____
Have you had any **MRIs** for this problem? If so, please list with dates _____
Have you had any **CAT Scans** for this problem? If so, please list with dates _____
Have you had this pain or problem before? _____
Have you had any **past surgeries or treatment** for this problem? _____
Please list any surgeries you have had with approximate dates _____
What are your goals for therapy? _____

Medical History – Please circle all that apply

Alzheimer's	Diabetes	Hernia	Osteoporosis
Asthma	Dizziness	High Blood Pressure	Pacemaker
Arthritis	Falls	Huntington's Disease	Parkinson's Disease
Blood Clots	Fainting	Lung Disease	Shortness of breath
Brain/Head Injury	Fibromyalgia	Lupus	Stroke/TIA
Cancer	Gout	Mental Health Illness	Swelling
Cardiovascular Disease	Headaches	Multiple Sclerosis	Thyroid Issues
Chest Pain	Heart Disease	Muscular Dystrophy	Unexplained Weight Loss
Current Infection	Heart Surgery	Nausea	Do you smoke? _____

Please list or attach current **Medications and/or Supplements**: _____
Have you had any Physical or Occupational Therapy this year? Please list: _____
Are you receiving or have you received **home health** care of any kind this year? _____
Do you have a pacemaker? Yes _____ **No** _____